The right to die: An up-date on the law

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The previous article on the right to die and Living Wills was published in the December 1990 issue of the Hawaii Medical Journal. In that article, the authors noted that "many observers believe that Hawaii's living will law will be improved in the next legislative session, so be alert to future bulletins or information on this issue." Since that statement was written, new Hawaii and federal laws have indeed clarified many of the rights and responsibilities of patients and health-care providers faced with treatment decisions at the end of life. The "new" rules are straightforward. Hawaii law contains some unique provisions that benefit patients and health-care providers. Much of the ambiguity of operating under the "old" rules has been eliminated. This article summarizes the current law and offers practical advice for physicians on how to work with the new rules.

A. The new Hawaii Living Will law

On May 6, 1991, by an overwhelming margin, the Hawaii State Legislature passed a new Living Will law, which became effective July 1, 1991. The law provides:

1. A strong public policy in favor of the person's right to refuse treatment. Hawaii law provides that "all competent persons (age 18 or over) have the fundamental right to control the decisions relating to their own medical care . . . The artificial prolongation of life for persons with a terminal condition or a permanent loss of the ability to communicate concerning medical treatment decisions, may secure only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the person."

2. How is the Advance Directive/Living Will executed? The person's written instructions must be signed by that person or by someone else in that person's presence and at the latter's instruction. It must be witnessed by 2 witnesses not related to the person and not involved with the person's medical care. The document must be notarized (all signatures at the same time).

3. A person's instructions do not have to be in writing, but it is strongly recommended; verbal statements given to PHYSICIANS are sufficient. Hawaii law also recognizes a verbal statement or statements if they are consistent, made by the physician or to the patient's friend or relative. Such statements "may be considered by the physician in deciding whether the patient would want the physician to withdraw or to withhold life-sustaining procedures." However, as a general rule, there are fewer potential problems with written directives. It is sound policy to encourage written advance directives instead of verbal ones.

4. The person's medical record. The advance directive is to be made a part of the person's medical record.

5. What the physician has to do. An attending physician who is aware and in possession of the patient's advance directive must immediately take steps to certify that the patient is now in the condition described in the person's Living Will. Thereafter, the attending physician must: a) follow as closely as possible the terms of the patient's directive, or b) if the physician is not willing to comply with the patient's advance directive, the physician must arrange for transfer of the patient to another physician's care without unreasonable delay.

6. Revocation. Hawaii law makes it easy for a person to revoke his or her advance directive. It may be revoked at any time after it was executed by various methods, both written and verbal, including tearing it up, an unambiguous verbal statement to two witnesses, or just by notifying the attending physician of a change of mind.

7. Euthanasia. Nothing in the Hawaii law is intended to condone, authorize, or approve mercy killings or euthanasia.

8. Effect upon life insurance/suicide. Honoring the terms of a person's advance directive does not constitute suicide nor modify the terms of payout in an existing policy of life insurance.

9. If there is no valid advance directive. Hawaii law also has a "catch-all" provision. In the absence of a valid advance directive, "ordinary standards of current medical practice will be followed." This phrase was interpreted in the Crabtree case (*Hawaii Medical Journal,* December 1990), to include withdrawal of life-sustaining medical treatment for a comatose woman if she had previously and unambiguously indicated that she did not want to be kept alive if she had no reasonable expectation of a meaningful recovery.

10. Other states. Hawaii law recognizes Living Wills executed in other states if the out-of-state document substantially complies with Hawaii law.

B. Strengths of the new Living Will law

1. The new Hawaii law greatly expands the category of who can execute a Living Will. It goes far beyond the old limitation of allowing Living Wills only for those in a "terminal" condition.

2. It specifically recognizes that although written instructions are preferred, verbal statements by the patient can be sufficient to allow withdrawal of life-sustaining medical treatment.

3. It specifically recognizes that nourishment and fluids may be declined just as any other medical treatment. However, the new law requires a unique check-off provision (see paragraph 6 of the accompanying model Living Will form).

4. It permits a simpler certification process by a single physician.

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(Editorial note: Steve Wallach was the 1991 to 1992 president of the HMA; he has an outstanding record of representing organized medicine's educational efforts in Hawaii and at the State Legislature. Jeff Crabtree, who practices law, brought the first case to the attention of the legal system in Hawaii, of the "right to die," on behalf of his mother at her terminal illness. This article is a collaborative effort by the two most well-informed authorities on the subject in our community.)

C. The new Hawaii law for health-care power of attorney

This new law became effective June 12, 1992. Hawaii law now expressly permits persons to appoint a substitute decision-maker (sometimes called a proxy or attorney-in-fact) to make health-care decisions for them if they become incapacitated as determined by a physician. This is a major improvement, because under earlier Hawaii law it was clear that such appointments were valid for financial decisions such as selling the family car or getting into bank accounts; however, the law was somewhat vague as to whether or not such appointments were valid for health-care decisions. Now, they clearly are valid, and a physician may legally rely on them in consulting with a patient's friends or family members (or whoever is appointed).

The person appointed as proxy is allowed to make the ultimate decision that may lead to the patient's death: To withdraw or withhold life-sustaining medical treatment such as tube feeding, hydration, or surgery. However, the proxy can make this decision only if such authority is explicitly set forth in the patient's health-care power-of-attorney document. If this specific wording does not appear, then it will be presumed that the patient did authorize the proxy to withdraw such forms of life-sustaining medical treatment.

D. The new federal law: The Patient Self-Determination Act

As of December 1, 1991, all states and most health care facilities must comply with new Medicare and Medicaid rules regarding each patient's right to control his or her health care treatment. The amendments are known as the Patient Self-Determination Act (PSDA), enacted by Congress and signed by President Bush as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (PL 101-508).

The new federal law applies to all Medicare and Medicaid organizations (not individual doctors), and specifically includes hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires them to provide written information to inpatients regarding their rights under state law concerning advance directives, maintain written policies about the institution's approach to advance directives, and includes other administrative and technical requirements concerning advance directives. The new federal law also forbids the health care organization from applying restrictive conditions on the provision of care or otherwise discriminating against a patient based on whether or not the patient has executed an advance directive.

The intent of the new federal law is to help individuals understand they have strong rights regarding their medical treatment, and to help them exercise those rights if they wish. This should help avoid problems and litigation over the initiation or continuation of unwanted, life-prolonging medical treatment.

E. Practical issues for physicians in Hawaii

1. Overview. These new laws have legalized what had been a growing trend across the United States—making it easier for

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patients to refuse futile or end-of-life treatment if they prefer to die. The patient has a basic right to be free of unwanted medical treatment, including life-sustaining treatment, such as food and water. Tube-feeding is considered a medical treatment which may be refused just as chemotherapy.

There is no longer any valid legal reason for physicians to insist automatically that a family should go to court in order for treatment to be withheld or withdrawn. This poses an enormous financial and emotional strain on the family and can cause inordinate delay. A fundamental purpose behind these new laws is that this most sensitive decision can remain where it belongs—between patients, their families and their doctors (and not lawyers and courts). Litigation should be reserved for situations where there is a doubt or conflict about what the patient's desires are.

2. If You Object. If you, the physician, for personal or other reasons, are unwilling to withhold or withdraw life-sustaining treatment from a patient who does not want the treatment, then you are obligated to refer the patient to another physician who will comply with the patient's wishes. Treatment of a competent patient against his or her wishes will probably constitute an assault and/or battery, and may subject the physician to civil or even criminal liability. The patient will probably not be obligated to pay for unwanted medical treatment.

3. Check the Living Will/Healthcare Durable Power of Attorney. If your patient executed such a document, read it. These documents are not uniform. Some (old) Living Wills may apply only to people in a terminal condition. Some Living Wills request that food and water, as an exception, be continued, ie not withdrawn (this is extremely rare, but possible). In other words, do not assume it is permissible to withhold or withdraw life-sustaining treatment just because the family says "Uncle Harry had a living will."

4. Verbal Statements. The physician should, of course, proceed with more caution if relying on verbal statements alone; especially those reported by family members, as opposed to those from the patient directly. There are lots of professional, community and institutional resources available for you, the physician, to consult when you are not sure what the patient would have wanted.

5. Verbal statements to you, the physician. The Hawaii law is very lenient with patients and physicians in this regard. Again, written directives are preferred, but if that is not feasible or likely, much confusion and doubt will be removed if physicians talk to their patients about withholding or withdrawing life-sustaining treatment before they suffer a debilitating accident or condition. Most surveys show that only 15% to 20% of the population have a Living Will or other reliable documentary evidence indicating their preferences concerning withdrawal of life-sustaining treatment in the event of profound disability. Most observers agree this is more a result of ordinary procrastination rather than an unwillingness to make a decision on the subject. The polls have also shown consistently that between 70% to 85% of persons queried do not want to be maintained on life-support treatment if they are severely disabled with no reasonable chance of recovery.

As a practical matter, this means physicians have an important opportunity to discuss the issue with their patients, especially those who will likely be seriously disabled in the foreseeable future. If the patients have formed opinions on the subject, their wishes are more likely to be honored if they are in writing or reported to a reliable and objective person, namely their attending physicians, and recorded in their medical record

6. The family's wishes do not count. It is what the patient wants (or wanted before becoming incompetent) that matters. If the patient never made his or her own wishes known to anyone, any withdrawal of life support based solely on family wishes is a very sensitive area that should be carefully considered with the help of counsel, an ethics committee, or some other reliable source. (This rule, however, does not apply where there is a valid Durable Power of Attorney for Health Care, because the whole purpose of such a document is to detail the wishes of a substitute decision-maker.)

7. Distributing forms/advance directives. If Hawaii physicians are offering a Living Will, Durable Power of Attorney for Health Care, or other similar directive to their patients at this time; they should make sure it complies with these new laws. The older forms are sometimes highly restrictive, and the new laws require "magic words" to be used on certain issues; withholding or withdrawing of life-sustaining medical treatment, especially nourishment and fluids. If you are handing out a form that does not comply with the new laws, even if you have good intentions, you are doing a potentially serious disservice to your patients. The Hawaii Medical Association can easily help you make this determination.

8. Your patient says: "No problem; I already have one of those." For any patient who already has a Living Will or a Durable Power of Attorney for Health Care, it becomes important to find out what it says and when it was executed. If the Living Will was executed before July 1991, it is probably the old, 1986 version. Invariably, the patient should sign a new one to take advantage of the broader rights under the new statute (assuming those patients want broader rights). Similarly, if the patient has a Durable Power of Attorney for Health Care executed before June 1992, the broad, general document will not meet the new statutory requirements that certain powers (including the power to withhold or withdraw life-sustaining medical treatment) be explicitly stated in the document. Again, it would probably be important for them to have a new one made.

9. How to help your patients get good advice regarding advance directives. There are a number of organizations, firms and community agencies available to help people get the right forms, fill them out correctly, and distribute them properly. A listing of some of them is included in this article.

The authors recommend to physicians: The following is a model Living Will form and instruction drafted by Crabtree. He has made it available for anyone to use. It meets the requirements of the recent 1991 and 1992 laws. Prior versions may now be defective, so if you are distributing earlier versions, you are encouraged to change to the new format, or consult with an attorney. You are free to reproduce this form on your own stationery, or on blank stationery, or any other form you may choose. It includes optional sample instructions which may help the patient fill out the form.

(See list of Community Resources Advance Directives on page 273.)